



Phone: 1-877-537-0722
FAX TO: 1-877-537-0720

Division of Medicaid
Pharmacy Prior Authorization Unit
550 High St
Suite 1000
Jackson, MS 39201

Preferred Drug List Exception Request
PRIOR AUTHORIZATION REQUEST FORM

Patient Name (Last) (First) MI	MS Medicaid 9 Digit ID #:	Date of Birth
Practitioner Name (Last) (First) (M I)	NPI# Medicaid ID #	
Practitioner Address (Street) (City) (State) (Zip)	Phone # Fax #	

Pharmacy Name & Address (City) (State)	Provider Number	Phone# Fax #
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Non-Preferred Drug Requested	Dose Directions	Phone# Fax #
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Diagnosis (Optional) Diagnosis Code (ICD-9-CM)

Please answer each of the following questions for your request to prescribe a non-preferred drug for your patient:*

1. Has the patient experienced treatment failure with the preferred products(s)? Yes No

1st Drug _____ Length of Therapy _____ Reason for D/C _____

2nd Drug _____ Length of Therapy _____ Reason for D/C _____

Attach additional documentation of other treatment failures with preferred drugs if necessary.

2. Does the patient have a condition that prevents the use of the preferred products(s)? Yes No

If YES, list the interaction(s) in the box below:

3. Is there a potential drug interaction between another medication and the preferred products(s)? Yes No

If YES, list the interaction(s) in the box below:

4. Has the patient experienced intolerable side effects while on the preferred product(s)? Yes No

If YES, list the side effects in the box below:

****MS Division of Medicaid requires that all information requested on this form be completed for consideration of approval.***

Practitioner Signature: _____ **Date:** _____

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